

**AN OVERVIEW OF INTERSTATE COMPARISONS
OF MEDICAL LIABILITY LAW,
LIABILITY REFORMS, AND LIABILITY
INSURANCE OPTIONS**

A REPORT TO THE SJR 32 SUBCOMMITTEE ON MEDICAL LIABILITY INSURANCE

Prepared by David D. Bohyer, Research Director

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Table 1 State-by-State Qualitative Analysis - Major Legislative Tort Reform Measures Ranked by Order of Number of Quality Measures								
State	<i>Mandated \$375,000 Or Less, No Exception "Cap" On Non-Economic Damages</i>	<i>Mandated Entry, Pre-Lawsuit, Non-Binding Screening Panel</i>	<i>Mandated Modified Joint & Several Liability - Proportional To Fault Only</i>	<i>Mandated Eliminate Duplicate Payments From Collateral Sources</i>	<i>Mandated Periodic Payment Of Future Economic Damage</i>	<i>Mandated Reduced Statute Of Limitation For A Minor</i>	<i>Mandated Legislative Cap On Contingent Fees</i>	<i>Prohibited Dollar Amount Damages In Initial Court Papers</i>
Montana	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
New Mexico	No	Yes	Yes	Yes	Yes	Yes	No	Yes
Wisconsin	No	No	Yes	No	No	Yes	Yes	Yes
California	Yes	No	Yes	No	No	Yes	Yes	Yes
Colorado	No	No	Yes	Yes	Yes	Yes	No	Yes
Indiana	No	No	No	Yes	No	Yes	Yes	Yes
Hawaii	Yes	Yes	Yes	No	No	Yes	No	Yes
Louisiana	No	No	Yes	No	Yes	Yes	No	Yes
Rhode Island	No	No	No	Yes	No	No	No	Yes

Source: Gerald J. Neely, G. Brian Zins, and Kathy Whitehead, *Year 2003 Montana Medical Legal Panel Report, Executive Summary*, p. 6, March 17, 2003

Background and Introduction

In the waning days of Montana's 58th Legislative Session, the House and Senate overwhelmingly adopted Senate Joint Resolution No. 32. The resolution requested an interim study of "the costs and availability of liability insurance for health care facilities and health care providers associated with health care facilities". Subsequent to the adoption of SJR 32, the respondents to the interim study poll ranked SJR 32 as first among 13 interim studies. As a result of the ranking and other factors, the Legislative Council created a subcommittee to conduct the study, specifically, the SJR 32 Subcommittee on Medical Liability Insurance (Subcommittee).

Beginning during the summer of 2003, the Subcommittee's staff compiled information that compares states' medical liability environment and legal liability reforms. The two most comprehensive compilations were developed, independently, by the National Conference of State Legislatures (NCSL) and the American Medical Association (AMA). Each of the compilations covers all 50 states and there is some overlap among the legal or reform categories included. However, there are also categories unique to each collection.¹ The two documents provided much of the information repeated or summarized in this paper.

The Issues

As characterized in SJR 32, the study issues are relatively straightforward: recent experience with and alarm from increasing rates for medical malpractice liability insurance (MMLI); and public policy options potentially available to address the problems identified. This installment of the study focuses on the directive from SJR 32 that the study examine "measures adopted by other states to address the liability insurance problems related to liability insurance for health care facilities and health care providers associated with health care facilities".

The information that follows is presented in two parts: (1) Montana's

¹ The NCSL effort and the AMA collection are each included herein, respectively, at Appendix A and Appendix B.

medical liability law and reforms; and (2) policy alternatives. The first category of information summarizes current Montana law and practice. The second category of information summarizes some of the legal alternatives for addressing or resolving medical liability issues.

The objectives of this report are twofold. First, because SJR 32 directs the Subcommittee to assess factors affecting the cost of liability insurance and because there are both perceptions and assertions that the status of a state's tort law may be or is a driver of insurance premiums in that state, the first part of the report attempts to articulate or clarify the status of tort law and tort reform in Montana, both individually and with respect to other states.

Second, because SJR 32 also directs the Subcommittee to examine measures adopted by other states to address liability insurance problems, strategies for increasing availability of affordable liability coverage, and strategies for resolving liability claims outside of the court system, the second category of information summarizes some alternatives adopted by or under consideration in some other states. Additionally, alternatives identified by individuals, academics, associations, et al., are also discussed in furtherance of the SJR 32 objectives.

PART 1: Montana Medical Liability Law and Reforms

Montana fairs very well in the category of enactment of "tort reform" measures, especially when compared with the states on the American Medical Association list of states that are "OK" in terms of the cost and availability of medical liability insurance, including a comparison with California, the claimed "Gold Standard" of tort reform. Montana fairs well both in terms of the type of legislation and the quality of legislation...

*Year 2003 Montana Medical Legal Panel Report
Executive Summary, February 13, 2003*

Overview

Montana's law regarding medical liability was in a state of transition from about the late-1980s through the mid-1990s. In part, long standing practices and traditions were actual or perceived impediments to the welfare of Montana citizens, medical providers, and medical facilities. Then, in 1995, during the 54th Legislative Session, the state's medical liability statutes were substantially revised to reflect policies adopted in other states, particularly California.² Since then, the state's Legislatures have mostly left medical liability statutes alone except when it was perceived that the Supreme Court has subverted legislative policy.

In short, Montana's medical liability laws currently reflect policies that are strongly advocated by medical practitioners, medical facilities, and medical liability insurers. Compared to other states, Montana's statutes now rank among the elite. Montana's law reflects a philosophy that:

- an injured party should be fully compensated -- no more, no less -- for all actual damages and sufficiently compensated for noneconomic damages;
- responsibility for damages should be determined and assessed on a proportional basis among those responsible for the injury;

² See House Bill No. 309, Ch. 461, Laws of Montana 1995.

- medical practitioners, medical facilities, and insurers should have some confidence in the predictability of liability insurance premiums and availability at a reasonable cost; and
- public policy should not result in adverse consequences for citizens, medical practitioners or facilities, or insurers and should, wherever possible, act as a catalyst to reduce unpredictability, stabilize or reduce liability insurance rates, increase the availability of insurance, enhance the image of Montana as a great place to practice or provide medical services.

Statute of Limitations: 27-2-205, MCA

Montana law requires a plaintiff in a medical malpractice action to commence the action within 3 years after the date of injury or within 3 years after the plaintiff discovers or through the use of reasonable diligence should have discovered the injury, whichever occurs last, but in no case may an action be commenced after 5 years from the date of injury. However, this time limitation is tolled for any period during which there has been a failure to disclose any act. However, for death or injury of a minor who was under the age of 4 on the date of the minor's injury, the period of limitations begins to run when the minor reaches the minor's eighth birthday or dies, whichever occurs first.

Underlying arguments for a statute of limitation include providing some assurance of a cause and effect relationship between the alleged act or omission and the injury claimed, as well as providing some predictability for practitioners, facilities, and insurers.

Underlying arguments against a statute of limitations or a relatively brief statute of limitations include situations in which the injury or its effects don't manifest until a significant period of time elapses during which the injured party is unaware that the injury has occurred.

Limits on Noneconomic Damages: 25-9-411, MCA

In a malpractice claim or claims against one or more health care providers based on a single incident of malpractice, Montana law limits an award for past and future damages for noneconomic loss to a maximum of \$250,000. All claims for noneconomic loss deriving from injuries to a patient are subject to an award not to exceed \$250,000. If more than one patient

claims malpractice for separate injuries, each plaintiff is limited to \$250,000 in noneconomic damages.

Underlying justification for limiting noneconomic damages relies heavily on the fact that all *economic* damages -- past, current, and future medical bills, loss of future earnings, etc. -- are completely covered, that noneconomic damages are difficult to value in economic terms, and that noneconomic damage awards can vary widely for similar injuries or that such awards can vary widely among different jurisdictions and even within the same jurisdiction.

Underlying arguments against limiting noneconomic damages include a recognition that the economic damages awarded to an injured party, although fully covered, may not reasonably value the worth of certain types of work, e.g., a housewife, or cannot reasonably value the future lost wages of a child. Thus, economic damages can vary substantially for virtually identical injuries suffered by different individuals without the possibility of a corresponding variation in noneconomic damages that would, in essence, result in equal treatment among individuals in similar circumstances. Additionally, there are certain injuries, e.g., loss of sight, movement, or sexual function, and circumstances, e.g., extraordinary pain, suffering, etc., for which an arbitrary limit or cap does not seem to adequately compensate for the injury.

Collateral Source Rule: 27-1-308, MCA

In Montana, the law states that in a case in which the damages exceed \$50,000, the total damages must be reduced by the amount of prior payment from collateral sources that do not involve rights of subrogation.. The judge -- rather than the jury -- applies the rule and is required by the statute to effect the offsets.

The underlying argument for the collateral source rule is to preclude a claimant from receiving payment more than once for the same injury.

Against the rule the argument is that reducing an award by amounts contributed from collateral sources rewards those who are culpable or responsible for the injury or damages at the expense of the injured party.

Joint and Several Liability: 27-1-703, et seq., MCA

In Montana, if the negligence of a party to an action is an issue, each party against whom recovery may be allowed is, with exceptions, jointly and severally liable for the amount that may be awarded to the claimant. However, each party that is negligent has the right of contribution from any other party whose negligence may have contributed as a proximate cause to the injury. An exception to the general rule occurs whenever a party whose negligence is determined to be 50% or less of the combined negligence of all parties determined to be negligent is severally liable only and is responsible only for the maximum percentage of negligence attributable to that party. Another exception is that a party may be jointly liable for all damages caused by the negligence of another party if both acted in concert in contributing to the claimant's damages or if one party acted as an agent of the other.

The advisability for reforming the joint liability doctrine, which Montana did in 1995 and 1997, is predicated on the belief that determining liability should be a system of comparative fault in which persons are held responsible only to the extent to which they cause or contribute to the harm. Further, advocates argue that joint liability reform should apportion liability among all tortfeasors according to their equitable share of fault, rather than only among parties to the action. It is argued that without the reform solvent defendants have to pay for the liability of insolvent, immune, or settled parties. In short, the reform limits the exposure of a defendant with a "deep pocket".

In contrast, arguments against reforming the doctrine include limiting the ability of an injured party and making it more difficult for the injured party to fully recover due compensation for the injury incurred.

Periodic Payments: 25-9-412, MCA

A party to an action for a medical malpractice claim in which \$50,000 or more of future damages is awarded may request the court to enter a judgment ordering future damages to be paid in whole or in part by periodic payments rather than by a lump-sum payment. If such a request is made, the court must enter an order for periodic payment of future damages. The total

dollar amount of the ordered periodic payments must equal the total dollar amount of the future damages without a reduction to present value. If the injured party dies prior to full payment of the award, the remainder of the award becomes part of the decedent's estate.

The arguments favoring periodic payments include the premise that guaranteed periodic payments, such as through an annuity, will assure that the injured party will have resources available for the duration of the injury or the life of the injured party. This approach provides some insurance that the injured party will not become a burden to the public fisc. A periodic payment schedule also allows the party responsible for making payment to better plan and accommodate the payments, compared to a one-time or lump sum payment.

First, in opposition to periodic payments, it is sometimes the case that the injured party may not survive to benefit fully from the award. In such cases, it is argued, the injured party is not only subjected to the injury that is the cause of action, but also to subsequent financial injury. Additionally, there is the argument that once the award is made the injured party should be given the full amount immediately as the award is considered to be full compensation *at the time the award is made* without having to adjust for or "crystal ball" the vagaries of future events, e.g., inflation.

Pretrial Screening: Title 27, chapter 6, MCA

Montana has a forum, the Montana Medical Legal Panel³, and *mandatory* process established to prevent where possible the filing in court of actions against health care providers and their employees for professional liability in situations where the facts do not permit at least a reasonable inference of malpractice. In cases where malpractice is reasonably suspected, the Montana Medical Legal Panel makes possible the fair and equitable disposition of claims against health care providers without the complexities, expense, and time-investment of the legal process.

The principal argument for pretrial screening is the same as the purpose of the Montana Medical Legal Panel; i.e., it gives both the injured and

³ There is also the Montana Chiropractic Legal Panel that screens claims of chiropractic malpractice. The forum and processes essentially parallel those of the Montana Medical Legal Panel. See Title 26, ch. 12, MCA.

accused parties the opportunity to have an objective "outsider" consider and comment on the claim prior to investing time, effort, and money in a legal process that might be avoidable. For example, if the Panel determines that the claim is wholly without merit, the claimant may drop the issue without any further action. Alternatively, if the Panel believes that the claim is meritorious, the defendant may reconsider negotiating and settling the claim outside the legal processes.

Arguments against the process include the additional time and, potentially, money that it takes, ultimately, to have a claim adjudicated in court -- time and money that plaintiffs frequently do not have. Additionally, there is the possibility that the claimant or the defendant, or both, might (mis)use the process only to preview or discover the strength of the evidence and arguments of the adversaries or the perceptions or conclusions reached by an objective deliberative body.

Expert Witness Rules: Title 26, chapter 10, part VII, Rule 702, MCA

The Montana Legislature has not enacted a statute defining the qualifications of an "expert witness" in medical malpractice cases. Rather, the Supreme Court has ordered, by Rule, that,

... if scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify thereto in the form of an opinion or otherwise.⁴

This rule is identical to Federal and Uniform Rules (1974) Rule 702.

Montana's Rule states the two common-law standards required before an

expert is allowed to give his or her opinion, each of which standards is found

⁴ Ad. Sup. Ct. Ord. 12729, Dec. 29, 1976, eff. July 1, 1977. The Montana Supreme Court adopts, revises, repeals, etc., the Rules of Civil Procedure. Those Rules are published in the MCA *only* as a matter of convenience and courtesy to the Judiciary and the Bar. Because the Rules are within the purview of the Judiciary--much like the Rules of the Legislature are within the purview of the Legislature--the Legislature has been "dissuaded" from attempting to revise, adopting, or repealing the Supreme Court's Rules.

in existing Montana law.⁵

Further, a party may through interrogatories require any other party to identify each person whom the other party expects to call as an expert witness at trial, to state the subject matter on which the expert is expected to testify, and to state the substance of the facts and opinions to which the expert is expected to testify and a summary of the grounds for each opinion. (See, Title 25, ch. 20, pt. V, Rule 26(b), MCA.)

According to the NCSL, 31 of the 50 states have statutes that address "expert witness" designation. The various states' statutes range from fairly weak or vague⁶ to fairly strong or definitive.⁷

Arguments in favor of establishing qualifications of "experts" *a priori* include precluding claimants or their attorneys from filing frivolous claims or, at least, mitigating the frequency and severity of the filing of frivolous claims.⁸

Arguments against specifying expert qualifications include the additional time and expense to the claimant involved in finding/hiring the expert, which some individuals perceive as barriers to due process of law.

Attorney Fees

Attorney fees or, rather, limiting attorney fees, is another on the checklist of liability laws or reforms.

For a few of the most adversarial cases, a claimant may feel compelled to retain legal counsel or, ultimately, to file a lawsuit. Reportedly, many or most of these cases are taken by legal counsel on a "contingency fee" basis, in which the attorney is compensated only if the claimant/plaintiff receives an award. The amount of the contingent fee varies, but is typically at least 30% of the award depending on the complexity

⁵ See "Commission Comments" in Title 26, ch. 10, pt. VII, 702, MCA.

⁶ Under Illinois code (735.5-8), the plaintiff is required to provide an affidavit stating that a competent expert has been consulted. (*State Medical Liability Laws Table*, NCSL, 2003.)

⁷ For example, the Michigan code requires that an "expert" must be a licensed health professional, practice in a similar specialty, be board certified (if required on the speciality) during the year preceding the action, and had clinical or academic experience in the specialty. A certificate of consultation must be filed with claim. (*State Medical Liability Laws Table*, NCSL.)

⁸ However, without requiring extremely stringent qualifications, it is very unlikely that what may be perceived by the accused practitioners or facilities to be "frivolous" claims will not be pursued by the claimant. More likely, there will always be an expert to be found who will attest to the merits of the claim. (Conversation with Larry Riley, Esq., Montana Defense Trial Lawyers Association, September 2003.)

of the case and the level of the legal system at which the case is ultimately resolved.

With respect to medical malpractice claims, Montana has not enacted limits on attorney fees⁹, whereas some other states have.

Arguments in favor of limiting legal fees include the fact that a sizeable portion of the compensation awarded to the injured party can be siphoned off by the claimant's attorney. Additionally, some interests contend that fewer claims would be filed or pursued if trial attorneys did not have the opportunity to recover (potentially) large sums as contingency fees.

Against placing limits on legal fees are arguments that injured, low income individuals would be shut out of the legal process if not for attorneys who are willing to gamble their own time and resources on the possibility that an award will be won. Further, those opposed to limits counter that the amounts received for some, perhaps many cases taken on contingency are insufficient to cover the cost incurred by the attorney for that case. Finally, opponents point to the significant legal resources available to medical providers and facilities: ample legal counsel (both quantity and quality); considerable financial resources for, e.g., discovery, expert witnesses, etc.; and the luxury of time, a commodity that many injured claimants have little of.

Contributory or Comparative Negligence or Fault: 27-1-702, MCA

The concept of contributory or comparative negligence or fault is closely associated with joint and several liability. Contributory negligence does not bar recovery in an action to recover damages for negligence resulting in death or injury if the contributory negligence was not greater than the negligence of the person or the combined negligence of all persons against whom recovery is sought, but any damages allowed must be diminished in the proportion to the percentage of negligence attributable to the person recovering.

The arguments pro or con are essentially the same as the arguments for or against joint and several liability. Essentially, by advocates, that liability should be borne in proportion to fault or, by opponents, that the injured party is potentially subjected to additional time and expense in order to gain

⁹ In Montana, attorney fees in Workers' Compensation cases are limited under 39-71-613, MCA.

compensation for the injury.

Vicarious Liability or Ostensible Agency: 28-10-103, MCA

The premise of vicarious liability or ostensible agency is that a person who causes, directly or indirectly, a second person to believe that a third person is employed by or is an agent of the first person is liable for damages caused to the second person by the third person even though the third person is not employed, *per se*, by the first person. The underlying premise of ostensible agency is also related to the concept of joint and several liability yet, on the surface, would seem to contradict the tenets of comparative fault.

Montana has recognized ostensible agency since its early days, having enacted the original statute in 1895 and leaving it unchanged since enactment.

As a factor in medical liability insurance, the Montana Supreme Court, in *Butler v. Domin* (2000 MT 312, 302 M 452, 15 P3d 1189, 57 St. Rep. 1320 (2000)) concluded that,

... a hospital will be deemed to have held itself out as a provider of care unless it gives notice to the patient that it is not the provider of care and that the care is provided by a physician who is an independent contractor and not subject to the control and supervision of the hospital.

With respect to ostensible agency, proponents would view the application of the tenet as a legitimate means to ensuring that an injured person could be fully compensated for an injury incurred.

In contrast, opponents would see little relationship between the person who actually causes the injury and a virtually uninvolved party who has merely contracted for the services of the party that caused the injury.

Prejudgment Interest: 27-1-210, MCA

In Montana, it has been a matter of statutory law for nearly 20 years and a judicial practice prior to the 1985 law that interest may be awarded on "on any claim for damages awarded that are capable of being made certain by calculation", i.e., actual damages but *not* noneconomic damages or court costs or attorney fees.

Arguments associated with prejudgment interest revolve around the

concept of the time-value of money and the pecuniary effects of inflation.

Summary of Montana Medical Liability Laws and Reforms

From time to time, Montana has been seen as a state in which liability was so liberally construed as to compromise the welfare of, in this instance, medical practitioners and facilities. And, similar to citizens in many other states, Montanans have witnessed the enactment, application, and revision of various legal elements that affect or are affected by the theoretical and practical implications of medical liability.

For good, ill, or naught, past Montana Legislatures have responded to the previously reported "crises" in medical liability and general liability through adopting legislation that articulates public policy with respect to assignment of liability, protection from liability, just compensation, proportionate accountability/responsibility, and economic reality. Over the past 20 years or more, Montana's Legislatures have gradually enacted or revised the state's laws to mitigate what have reportedly been the most egregious legal liability pitfalls, gravitating to the point where Montana is now recognized, by some at least, to be as "medical-liability-insurance friendly" as nearly any other state.¹⁰

¹⁰ See, e.g., Gerald J. Neely, G. Brian Zins, and Kathy Whitehead, *Year 2003 Montana Medical Legal Panel Report, Executive Summary*, March 17, 2003; *Medical Malpractice: Implications of Rising Premiums on Access to Health Care*, U.S. General Accounting Office, August 2003, p. 17-21. (GAO-03-836); *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increases Rates*, U.S. General Accounting Office, June 2003, pp. 22, 45,. (GAO-03-702).

PART 2: Policy Alternatives

Overview

Part 1 of this report essentially concludes that whatever forces are driving the increasing prices of and decreasing availability¹¹ of medical liability insurance, Montana's tort law is probably *not* one of the factors. In fact, if the tort law policies advocated by, e.g., the American Medical Association, et al., truly have the results that the AMA predicts they should have, Montana's tort law should be acting to mitigate price increases and enhance the availability of medical liability insurance. Thus, public policy makers must look at other alternatives to identify different changes in public policy to further promote liability insurance price reduction and availability or at least stability in both price and availability.

Certificate of Merit

A certificate of merit requirement would require a plaintiff to obtain an expert assessment of the claim at the outset of the suit. As characterized by Catherine T. Struve,¹²

Some 17 states currently impose certificate of merit requirements in medical malpractice actions. The goal in each state appears similar: to deter plaintiffs from filing meritless claims. Each state's certificate of merit provision requires the plaintiff to provide a certification that the case has been reviewed by an expert and that the expert has concluded there is some basis for the claim. Beyond this essential similarity, however, the provisions vary significantly. (Struve, p. 48)

The applicability of the certificate (medical malpractice only or other professional liability as well), plus the person who must certify and certificate content can and do vary from state to state. For example:

¹¹ Information provided by the Montana Insurance Commissioner shows that the number of insurers offering medical liability insurance has remained quite steady over the past several years, with some insurers exiting the market and others entering.

¹² *Expertise in Medical Malpractice Litigation: Special Courts, Screening Panels, and Other Options*, by Catherine T. Struve, for The Project on Medical Liability In Pennsylvania, Pew Charitable Trust, pub, Columbia University, c. 2003. The Certificate of merit requirements applicable to medical malpractice actions exist in Colorado, Connecticut, Florida, Georgia, Illinois, Maryland, Michigan, Minnesota, Missouri, Nevada, New Jersey, New York, North Carolina, North Dakota, Pennsylvania, Texas, and West Virginia. (Struve, p. 48.)

- does the plaintiff's "expert" certify that the claim is meritorious or does the plaintiff's attorney certify that an expert has reviewed the claim for merit?
- at what level of specificity is the standard of care required to be stated?
- at what level of specificity must the breach of the standard of care be stated?
- at what level of specificity must the breach of the standard of care be identifiable as the cause of the injury and be stated?
- is there simply a requirement that the expert certify that the claim is not meritless or unjustifiable?

In her research, Struve found that the empirical evidence regarding the efficacy of certificate of merit requirements is scarce and that what evidence there is does not seem to support the "deterrence theory".¹³

Relying on Struve's research, any certificate of merit requirement should have components that are (1) based on the goal of the provision and (2) the potential adverse effects. Stipulating that some form of "screening out weak malpractice claims" is the goal of a certificate of merit, the legal requirement should require the plaintiff's attorney that he or she has consulted an "expert" and the expert has reasonably determined that the defendant *negligently* caused the plaintiff's injury.¹⁴

Among the potential adverse effects is the availability of and access to information about the injury. While medical records may be available, the defendant and others may not be available for interviews. Further, legal restrictions to accessing medical records may preclude the timely review of relevant records.¹⁵

Another adverse effect is the cost of obtaining a certificate. The expert will likely not render a professional opinion for free and even the plaintiff's attorney may require the plaintiff to pay for the expert "up front".

¹³ Ibid., p. 50.

¹⁴ Ibid., p. 51.

¹⁵ Ibid, pp. 51-52.

Sometimes, one expert may be hired to obtain the certificate and another expert retained for trial, thus potentially doubling the expense.¹⁶

Finally, requiring a certificate of merit as a prerequisite may violate a plaintiff's constitutional right of equal access to the courts¹⁷, right to trial by jury¹⁸, or right to equal protection.¹⁹

Screening Panels

Montana's medical legal panels were addressed previously in this report but fall within this category of "alternatives" nevertheless. Montana's current process could be revised to, for example, alter the composition of the panels, reduce or expand the time allowed for panel review or decision, revise the amount of discovery or types of evidence allowed, scope of findings, or (possibly) allow or require the findings, conclusions, and decision of the panel to be admissible at trial. It must be noted, however, that the efficacy of such panels, in general, is questionable and the limited research suggests "that panels have not brought much overall improvement in malpractice litigation"²⁰ -- *the experience of the Montana Medical Legal Panel notwithstanding*.²¹

Study on the effects that panels may have on the frequency and severity of claims is inconclusive, possibly because of the lack of empirical research. What little can be inferred from the research suggests that panels have little

¹⁶ Ibid., p. 52.

¹⁷ See, e.g., *Aldana v. Holub*, 381 So.2d 231 (Fla. 1980); and *Cardinal Glennon Mem. Hosp. v. Gaertner*, 583 S.W.2d 107 (Mo. 1979). (Cited in Struve, p. 57, footnotes 1 and 3.)

¹⁸ See, e.g., *Mattos v. Thompson*, 421 A.2d 190 (Pa. 1980). (Cited in Struve, p. 57, footnote 4.)

¹⁹ See, e.g., *Hoem v. State*, 756 P.2d 780 (Wy. 1988). (Cited in Struve, p. 57, footnote 6.)

²⁰ *Expertise in Medical Malpractice Litigation: Special Courts, Screening Panels, and Other Options*, by Catherine T. Struve, for The Project on Medical Liability In Pennsylvania, Pew Charitable Trust, pub, Columbia University, c. 2003, p. 56.

²¹ The Panel has concluded that "Montana's Medical Legal Panel - which "screens" medical liability claims as a pre-condition to any lawsuit - has produced and is directly responsible for one of the lowest, if not the lowest, rates of medical liability court cases in the United States. This is readily-observable from the rate of lawsuits prior to the existence of the Voluntary Screening Panel that pre-dated the current Mandatory Panel, during the later period of no panel and during the period of the current Mandatory Panel, when contrasted with national and state studies of rates of lawsuits." (Gerald J. Neely, G. Brian Zins, and Kathy Whitehead, *Year 2003 Montana Medical Legal Panel Report, Executive Summary*, March 17, 2003, p.2.)

effect on either the frequency of claims or severity of claims paid.²²

In addition to the remaining questions regarding frequency and severity of claims, conclusions about the effects that panel have on insurance premiums are mixed. One longer-term (13 years) study found "no statistically significant effect on premiums for general practitioners or general surgeons (though it did find that panels were associated with a statistically significant reduction in premiums for obstetrician-gynecologists).²³

Possible adverse effects of panels or of changes to Montana's existing panel include additional time/expense involved for final resolution, more expense involved in discovery, scheduling difficulties, and even "trying the case twice".

Specialized "Medical Malpractice" Courts

The underlying premise for advocates of medical malpractice courts is that increasing the specialization and expertise among judges would be beneficial to all involved: plaintiffs, defendant-practitioners, and insurers. More judicial expertise in medical issues, it is argued, could enhance the speed and the consistency and coherence of outcomes. Additionally, expert judges might be better able to assess the qualification of "expert" witnesses or the "reasonableness" of awards for both real and noneconomic damages, as well as provide other procedural and substantive benefits.

A corollary premise is that an expert judge can better determine the "standard of care" threshold than can a jury, that the standard of care is more a matter of law (within the judge's purview) than it is a matter of fact (with the jury's purview), and that, as a matter of law, judges' decisions in

medical malpractice cases could set precedents for guiding physicians' subsequent conduct.

²² *Expertise in Medical Malpractice Litigation: Special Courts, Screening Panels, and Other Options*, by Catherine T. Struve, for The Project on Medical Liability In Pennsylvania, Pew Charitable Trust, pub, Columbia University, c. 2003, pp. 60-64.

²³ Primary source of conclusion found in Zuckerman, Stephen, Randall R. Bovbjerg, and Frank Sloan. 1990. Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums. *Inquiry* 27(2):167-82. Cited in Struve, p. 65.

The adverse implications of specialized courts include the cost to establish a separate judicial system within the existing system, the simple fact that there may be and typically are more than one legitimate approach to diagnosis or treatment that would or could be viewed to meet the "standard of care", and that the precedential value of judges' decisions is questionable due to the rapid pace of change in medical knowledge, understanding, technology, therapies, etc.

Moreover, there is a risk of "politicizing" the medical malpractice bench. Struve notes that "[C]ommentators have long pointed out that the more specialized a court is, the greater the incentives and opportunities for interest groups to seek to influence the court's decisions, both by lobbying to select judges who will favor the desired position and by exerting pressure on the court in connection with particular cases."²⁴ The risk of politicization is exacerbated if judges are elected.

A specialized court would, over time, narrow the perspectives of its judges by focusing their attention in only one area rather than expanding their vision among various areas. With narrower focus, specialized judges could become unaware of parallels to be drawn from other areas and potentially diverging from the larger body of law.²⁵

The cost implications accrue not only to the public fisc, but also to the plaintiffs -- it is highly unlikely that the number of medical malpractice courts would equal the number of district courts or that a specialized court would be located as close to plaintiffs as district courts do currently. Additionally, fewer and more distant trial venues would increase costs for juries, including selection, expense reimbursement, etc.

To counter some of the potential disadvantages of a specialized court discussed above, Struve offers some provocative suggestions.

If trial judges lack skill in assessing the admissibility of expert testimony, judicial training sessions could improve their understanding of the scientific method, probabilistic evidence, and other relevant topics. If specialized judges remain desirable, a separate court is not the only way to provide

²⁴ *Expertise in Medical Malpractice Litigation: Special Courts, Screening Panels, and Other Options*, by Catherine T. Struve, for The Project on Medical Liability In Pennsylvania, Pew Charitable Trust, pub, Columbia University, c. 2003, p. 73.

²⁵ See, e.g., *Ibid*, pp. 75-76, for a more complete discussion.

them. A specialized medical malpractice division could be created within a particular county's Court of Common Pleas, and judges could rotate into and out of that division. This option could reduce the politicization and perspective-narrowing problems identified above, while providing an opportunity for judges to gain concentrated experience in malpractice litigation. A specialized division, moreover, would not force litigants to travel large distances in order to pursue medical liability claims.... Those concerned principally with variations in jury awards, rather than judicial competence, might consider other reforms that tackle the jury issue directly, such as benchmarks to guide damage calculations.²⁶

Expert Witnesses

Recognizing that the issue of expert witnesses in the context of Montana law was touched upon previously, tort reform advocates point to unqualified "experts" being allowed to testify as one factor that leads to undesirable outcomes, not only disproportionate awards but even unjustified or unproved verdicts finding malpractice where none existed. There are at least two options available to address this concern: (1) expert qualifications that are higher, stricter, more definitive, etc., than may currently be present; or (2) allowing the judge, rather than the plaintiff and defendant, to select a "neutral" expert.

On their face, either option could be seen as a credible, objective move toward "finding the Truth" and away from the traditional approach of simply pitting one expert against another. Furthermore, each option has suboptions to consider, e.g., a court appointed "expert" to determine or evaluate the qualifications of (especially) the plaintiff's expert, or a court appointed expert to sift through the complexities of the case or contradictory findings or testimony of other experts and objectively synthesize the expert testimony for the jury.

²⁶ See, e.g., *Ibid.*, pp. 80-81.

*Jury Education*²⁷

Rather than treat jury members as passive actors waiting to be persuaded by various experts, the court could act to inform juries of the rules of evidence prior to the trial actually beginning. There is also the possibility of providing instructions to the jury before, as well as after, testimony is given. Periodic summaries of evidence, key exhibits, etc., by the attorneys or the judge could also help jurors to separate the wheat from the chaff.

The possible downside is that additional time and expense would be a near certainty.

Variability of Jury Awards

To the extent that variability of jury awards is inherently undesirable or bad, providing legislative guidance in structuring how damages, particularly noneconomic damages, are assessed is arguably an option.²⁸ Struve²⁹ again identifies variations on the theme that could include:

- lawyers could be permitted to frame their arguments concerning damages around prior awards in cases they consider comparable;
- juries could be given one or more stylized scenarios and associated valuations to use as benchmarks in considering how much to award;
- awards could be set by means of "a matrix of values" that would award fixed damage amounts according to the severity of injury and age of the injured party,"
- awards could be constrained by "a system of flexible floors and ceilings" that vary with injury severity and victim age";
- instead of arguing damages to the jury (which would only determine factual matters, e.g., malpractice), lawyers could be required to make a similar case to the judge (who would establish damages as a matter of law, not fact);
- require that any award that deviates materially from reasonable compensation will result in *remittitur* if the jury award is excessive. (By implication, this options suggests that an inadequate award will result in *additur*.)

According to David Sclar and Michael Housman writing in the *Harvard Health Policy Review* point to emerging reform proposals that:

²⁷ See, e.g., *Ibid.* pp. 87-90.

²⁸ This option is "arguable" due to the right to "full legal redress" provided under Art. II, sec. 16, Montana Constitution.

²⁹ *Expertise in Medical Malpractice Litigation: Special Courts, Screening Panels, and Other Options*, by Catherine T. Struve, for The Project on Medical Liability In Pennsylvania, Pew Charitable Trust, pub, Columbia University, c. 2003, p. 88.

... would significantly alter the process for resolving claims, as well as physicians' relationship to malpractice liability, in some cases removing the physicians from the process entirely. These new reform proposals fall under four categories: alternative dispute resolution, enterprise liability, selective no-fault malpractice compensation and clinical practice guidelines as the standard of care.³⁰

Alternative Dispute Resolution

Alternative Dispute Resolution or ADR is an increasingly common approach to determining facts, assigning responsibility, assessing damages, or a combination. To date, ADR is not used extensively in medical malpractice cases, but is becoming increasingly present in general liability. Relying again on the observations of Sclar and Housman:

Alternative Dispute Resolution (ADR) can come in many different forms that ultimately remove disputes from the judicial system and place them in the hands of one or more professional arbitrators, thus eliminating the jury. Some forms of ADR include arbitration, mediation, neutral evaluation and summary jury trials. In the case of arbitration, the decision can be non-binding in that a party can continue to pursue the claim within the legal system if he is not pleased with the result, or, on the other hand, the decision may be the arbitrator's, in which case the option of court appeal is limited. The decision to submit the case to binding or non-binding arbitration is voluntary, and must be made before the case has been heard. In the past, arbitration has been infrequently used to resolve malpractice claims, but extensively used in commercial settings, and it has been demonstrated to be less costly in resolving disputes.³¹

Enterprise Liability

A common practice in general corporate law, "enterprise liability", is a relationship in which the corporation assumes liability rather than the employee.

Under this system as it would apply to medical liability, a hospital, clinic, or other enterprise would assume liability for any alleged malpractice

³⁰ *Harvard Health Policy Review*, "Medical Malpractice and Physician Liability: Examining Alternatives to Defensive Medicine", by David Sclar and Michael Housman, Spring 2003, Vol. 4, No. 1; Internet URL: <http://hcs.harvard.edu/~epihc/currentissue/sclar-housman-e.php>.

³¹ Ibid. p. 2 on Internet version.

committed by a physician who works in the hospital, clinic, etc.³² There are clear advantages to this approach according to Sclar and Housman:

The major advantage that enterprise liability poses over the medical malpractice trial system, as it is currently structured, is that it relieves the physician of personal liability.... Furthermore, it compels the healthcare institution to more closely monitor the care that is given to its enrollees, and to take responsibility for quality improvement.³³

Potential drawbacks to enterprise liability include the changes in the relationship between the physician and the facility. Almost certainly those changes would result in a reduced level of autonomy for the practitioner, both in the way that he or she prefers to practice medicine and in the manner in which he or she behaves as an employee rather than as a privileged physician.

One thing that would not change would be that a physician accused of malpractice would continue to have his or her diagnoses, actions, and professional judgment subjected to scrutiny and criticism, even though he or she would avoid any liability if malpractice were found to have occurred.

Selective No-fault Liability

The concept of selective no-fault liability proffered for medical liability is not unlike the decades-old "workers' compensation" system. In practical terms, a no-fault system would replace the fault-based tort liability system with a list of adverse outcomes from medical care for which claimants/victims would be compensated for economic loss, regardless of the acts or omissions of a medical practitioner or facility. The list would be limited to "avoidable classes of events" or ACEs and to each ACE would be attached a mechanism for determining compensation. Victims of ACEs would be automatically compensated merely as a result of the injury and without any finding of fault.

³² It is unclear in reading Sclar and Houseman whether or not enterprise liability coverage extends to everyone who works in the enterprise or only for those who work for the enterprise. This is an important distinction because most hospitals grant "privileges" to physicians to treat patients in the hospital, but many or most privileged physicians also have private practices of their own, as part of a group practice, a limited liability partnership, etc. Consequently, privileged physicians are not "employees" of the enterprise as is the case in the context of enterprise liability as it applies in the general corporate world.

³³ Ibid, *Sclar and Housman*, p. 2 on Internet version.

Selective no-fault liability is limited in practical application, however, because it would be impossible to identify, catalog, evaluate, and appraise the economic value of every conceivable ACE in every conceivable set of circumstances.

Florida has adapted a very specific version of "no-fault" with its NICA program (Neurological Injury Compensation Association). Created in 1988 at the height of Florida's last malpractice insurance crisis, the NICA program is designed to stabilize the insurance market against catastrophic birth-related injury claims, ensure that most of the payments go to patients instead of lawyers, both plaintiff and defense, and provide reasonable benefits to the injured child's parents. Under fairly rigid criteria, outside medical experts scrutinize an a potentially eligible child's medical records prior to determining a NICA award or benefit.

The *Palm Beach Post* reported³⁴ that fewer than 175 children have been covered by NICA since 1988. The report also cited a study conducted by faculty at Duke University and Vanderbilt University that concluded that under NICA, "beneficiaries broke even" while families that received awards through tort settlements were "overcompensated". Notably, NICA doesn't account for a child's loss of income where tort settlements and verdicts typically do.

Clinical Practice Guidelines

One of the more forceful propositions, clinical practice guidelines or CPGs take the concept of "standard of care" to a somewhat higher level in which the standard is specifically laid out in a volume of guidelines. If adopted, typically through legislation, CPGs would immunize physicians from suit provided that the applicable CPGs were followed, even where the clinical outcome was adverse to the patient. Sclar and Housman are clear in their description of perceived advantages of CPGs.

... clinical practice guidelines actually provide physicians with guidance on which medical practices are beneficial to the patient and which are either wasteful or potentially harmful. In this respect, CPGs have the potential to end clinical practices that began for defensive reasons and have long since

³⁴ "Malpractice alternative pays less", *PalmBeachPost.com*, June 15, 2003, Internet URL http://www.palmbeachpost.com/business/content/business/insurance_myths_061503.html

become ingrained in the physician's mentality as the standard of care. Furthermore, court admission of the clinical practice guidelines ensures that clinical standards are the basis for determining cases. They may therefore eliminate the need to solicit testimony from expert witnesses who can carry widely divergent opinions regarding appropriate medical practice...³⁵

Among the potential disadvantages of CPGs, Sclar and Housman are just as clear.

Drafting and applying clinical practice guidelines are not yet perfect processes, and face a number of challenges. Clinical guidelines must leave room for physician discretion since real-life clinical scenarios are rarely black and white. The uncertainty in medicine makes CPGs difficult to create for certain treatments and procedures in which the standard of care is unclear. Furthermore, it becomes difficult to create clinical guidelines for every procedure imaginable, so there will certainly be some malpractice trials for which clinical guidelines are unavailable and proceedings revert to reliance on expert testimony and subjective judgments about malpractice. Consequently, the use of clinical guidelines may be limited, and may therefore only have an impact on certain cases of malpractice litigation.³⁶

Insurance Market Interventions

Insurance market interventions are identified by the National Governor's Association as "stopgap solutions that address the lack of affordable or available insurance, such as providing subsidies to providers or creating state-run insurance programs. These measures typically are thought of as short-term or providing an option of last resort and may not solve the systemic issues that insurers and providers believe exist in the medical liability insurance market."³⁷ The following descriptions, as compiled and summarized by the National Governor's Association, outline several insurance market interventions.

- State-Run, Stop-Gap Medical Malpractice Liability Coverage. The state establishes its own insurance fund from which doctors can purchase insurance if there is no other insurance carrier on the market. Typically overseen in the department of insurance and administered by a third party administrator, these funds try to relieve the immediate crisis and provide immediate relief to physicians unable to find affordable insurance. **Nevada** and **West Virginia** established state-based medical malpractice insurance funds in 2002 in order to relieve the current shortage.... The benefit of this type of fund is that it solves

³⁵ Ibid. *Sclar and Housman*, p. 3 on Internet version.

³⁶ Ibid.

³⁷ *Issue Brief*; "Addressing the Medical Malpractice Insurance Crisis", Emily V. Cornell, National Governor's Association, December 5, 2002

the immediate shortage of available insurance but not always of affordable insurance. In addition it is difficult to price premiums that are affordable without putting the state at risk for being the sole insurer in the state. In West Virginia, the state was required to price premiums higher than what was available in the commercial market in order to not compete with the commercial market.

- State Patient Compensation Programs. Patient compensation funds spread the cost of high awards more broadly. The state creates a fund that pays the portion of a judgment or settlement against a health care provider that exceeds a designated amount— such as \$200,000 per occurrence and \$600,000 annually. The fund pays the remainder of the award or it may have a maximum – such as up to \$1 million. The provider is responsible for awards beyond the funds' maximum unless a corresponding limit on medical liability applies. These funds are funded through an annual surcharge assessed against healthcare providers that participate in the fund, and participation can be mandatory or voluntary. Seven states—**Indiana, Louisiana, Nebraska, New Mexico, North Dakota, South Carolina, and Virginia**— operate voluntary systems, and three states—**Kansas, Pennsylvania, and Wisconsin**—operate mandatory programs. Since patient compensation funds help spread the risk more broadly, they help maintain the availability of medical malpractice insurance. However, it means that health care providers may pay two premiums for malpractice insurance, and therefore does not address the affordability issues.
- State Subsidies to Providers. The state establishes a mechanism that subsidizes all or a portion of the provider's insurance premium. This type of system could be set up as a one-time fund or continue for a limited number of years until insurance premiums stabilize. Subsidies could be made available to all providers, to a select group of providers who practice in high-risk specialties, or to providers in a select medically underserved geographical area within a state. Subsidies are simple to administer and easy to sell politically, especially if they are targeted to providers in a geographically underserved area. However, they do not address the underlying reason for high premiums. **Arizona, Hawaii, Illinois, Louisiana, Maine, Nevada, New York, North Carolina, Texas, and Washington** have tried this approach in the past to solve an immediate crisis. These programs were established in the late 1980s and abandoned as the liability crisis abated.
- Joint Underwriting Associations. A Joint Underwriting Association (JUA) is a state sponsored association of insurance companies formed with statutory approval from the state for the express purpose of providing certain insurance to the public. JUAs are usually formed because the voluntary market is unwilling to write coverage. The advantage of a JUA is that it spreads the risk across several companies, instead of one. They may cease when the voluntary market becomes available for that line of business. JUAs address the lack of insurance. However, insurance from a JUA typically is more expensive than from the private market, since it is the insurer of last resort, particularly for high-risk specialties who have no other choice.
- Physician Insurer Associations or Physician Mutual. Physician insurer associations are physician owned and operated insurance companies that provide medical liability [insurance]. These insurance companies began in the 1970s during the first medical liability crisis. Doctors, with the support of medical and hospital associations, contributed their own funds as capital to start as many as 100 provider-owned specialty carriers across the country. They have been dubbed "bed pan mutuals" by their commercial competitors. Currently, physician insurance companies insure over 60 percent of the nation's practicing physicians. Physician insurer associations create other carriers in the market to provide malpractice insurance and therefore address access to insurance for physicians. However, there is no indication that these types of insurance carriers are immune from the same issues that have driven out other commercial insurance carriers.
- State-Funded Indemnity for Specific Services. State-funded indemnity offers liability coverage for providers who typically have a relationship with the state--either through the

state university hospital or another type of public hospital system--and who provide critical emergency services. A state indemnity program typically covers a claim against a physician when the physician is working directly for a city, county or state and/or providing specific services such as trauma or obstetrical. The liability is shifted from the provider to the government, and all claims are brought against the state rather than the provider. This option address helps cover providers who serve low-income populations and target liability protections to the groups of providers that have been hardest hit. However, there is the risk that the state becomes the deep pocket in malpractice cases.

Another option, *captive insurers*, is not discussed here because Montana has already adopted legislation authorizing the creation and operation of captive insurers. A captive insurer is so named because it is owned by the insureds. As of this writing, several Montana hospitals are pursuing the creation of a captive insurance company.³⁸

Insurance Reform: California's Proposition 103

Aside from the insurance market interventions discussed above, there are other insurance reforms available to public policy makers. Prominently among them is Proposition 103-type reform. California's Proposition 103 is a 15-year-old initiative composed of six primary elements:

- Mandated an immediate rollback of rates of at least 20% – rate relief to offset excessive rate increases by establishing a baseline for measuring appropriate rates.
- Froze rates for one year. Ultimately, because of the delay caused by insurance company legal challenges to Proposition 103, rates remained frozen for four years pursuant to decisions by the state's insurance commissioner.
- Created a stringent disclosure and "prior approval" system of insurance regulation, which requires insurance companies to submit applications for rate changes to the California Department of Insurance for review before they are approved. Proposition 103 gives the California Insurance Commissioner the authority to place limits on an insurance company's profits, expenses and projections of future losses (a critical area of abuse).
- Authorized consumers to challenge insurance companies' rates and practices in court or before the Department of Insurance.
- Repealed anti-competitive laws in order to stimulate competition and establish a free market for insurance. Proposition 103 repealed the industry's exemption from state antitrust laws, and prohibited anti-competitive insurance industry "rating organizations" from sharing price and marketing data among companies, and from projecting "advisory," or future, rates, generic expenses and profits. It repealed the law that prohibited insurance agents/brokers from cutting their own commissions in order to give premium discounts to consumers. It permits banks and other financial institutions to offer insurance policies. And it authorizes individuals, clubs and other associations to unite to negotiate lower cost group insurance policies.

³⁸ Testimony of Claudia Clifford, Office of the State Insurance Commissioner, in *Minutes*, SJR 32 Subcommittee on Medical Liability Insurance, September 22, 2003.

- Promoted full democratic accountability to the public in the implementation of the initiative by making the Insurance Commissioner an elected position.

The proponents of Proposition 103 remain foursquare behind the initiative and, with no disrespect to California's MICRA³⁹, contend that:

... the most effective way to protect consumers and ensure reasonable insurance rates is through the tools of a prior approval insurance regulation system. Our research has shown that insurance company regulation, when properly implemented, can save consumers billions of dollars and maintain profitability within the insurance industry, thereby providing customers with the most choice in the market. In other words, the regimen of insurance regulation creates the environment that is most conducive to marketplace competition while also affording consumers necessary protection against insurance company profiteering....

Proposition 103 worked. Insurance companies refunded over \$1.2 billion to policyholders, including motorists, homeowners and doctors. In the closely studied area of auto insurance, California was the only state in the nation in which auto insurance liability premiums actually dropped between 1989 and 2001, according to NAIC data. A 2001 study by the Consumer Federation of America concluded that the prior approval provision of Proposition 103 blocked over \$23 billion in rate increases for auto insurance alone through 2000.⁴⁰

³⁹ Medical Injury Compensation Reform Act of 1975 (California; MICRA 1975).

⁴⁰ "Proposition 103: A Model for Insurance Regulation", Testimony of Douglas Heller, Foundation for Taxpayer and Consumer Rights, Before the Committee on Commerce, Science and Transportation United States Senate, Washington, D.C., October 22, 2003

PROVISIONS OF CALIFORNIA PROPOSITION 103
AFFECTING THE RATE REGULATION DIVISION, CALIFORNIA DEPARTMENT OF INSURANCE Source:
California Department of Insurance, Rate Regulation Division.

Regulation Prior to Proposition 103: Prior to the passage of Proposition 103 on November 8, 1988, the California Department of Insurance operated under the McBride-Grunsky Insurance Regulatory Act. Under this Act, insurance companies were not required to file rates for approval except for health and life. California was considered an "open competition" state in which competition regulated the marketplace. The Consumer Services Division was responsible for monitoring insurance companies' rating practices. On December 16, 1988, Rate Filing Bureaus were created in the Rate Regulation Division (RRD) to implement the following provisions of Proposition 103.

Rollback Provision: Proposition 103 required that every insurer reduce its rates to at least 20% less than the rates that were in effect on November 8, 1987 unless such rollback would lead to a company's insolvency. This provision was later changed by the California Supreme Court to allow companies a fair rate of return. Since 1989, the RRD has been responsible for negotiating with insurance companies to meet their rollback obligations.

Personal Automobile Rating Factors: Another major provision of Proposition 103 dealt with personal automobile insurance. In Section 1861.02 (a) of the CIC, personal automobile insurance rates must be determined using the following factors in decreasing order of importance--insured's driving safety record, number of miles driven annually by the insured, and number of years of driving experience the insured has had. In addition, the commissioner could specify other rating factors that have a substantial relationship to the risk of loss. As such, the RRD required insurance companies to submit automobile classification plans which complied with these codes and emergency regulations. Permanent regulations are being developed.

Good Driver Discount Provision: Proposition 103 also stated that an insurer could not refuse to write an applicant that qualifies for a good driver discount. Further, the good driver discount should be at least 20% below the rate the insured would otherwise have been charged for the same coverage. Proposition 103 indicated that a person qualifies for a good driver discount if s/he meets all of the following criteria--licensed to drive a motor vehicle for the previous three years, has not had more than one violation point during the previous three years, and was not a driver of a motor vehicle involved in an accident which resulted in death or in total loss or damage exceeding \$500, and was principally at fault. Accordingly, the RRD reviews companies' automobile classification plans and individual insurance policies to ensure these provisions are followed by insurance companies.

Prior Approval of Filings: Beginning November 8, 1989, property and casualty insurance rates must be approved by the insurance commissioner prior to use. As the Code continues to state that every insurer desiring to change any rate must complete a rate application with the commissioner, the RRD established a rate application that companies must complete if they wish to make any adjustments to their rates. Such rate applications are reviewed for acceptability by the Rate Filing Bureaus within the RRD. Weekly, a list of filings that have received approval letters is issued by Rate Regulation.

Public Notice: Section 1861.05 (c) of CIC indicates that public notice must be given for all rate applications. To meet this public notice requirement, the RRD issues a public notice every Friday of prior approval rate filings and file and use filings that have been received and meet basic compliance. The Rate Enforcement Bureau of the California Department of Insurance will send a copy of the public notice to any person or business free of charge.

Deemer Provision: Proposition 103 also stated that an application is deemed approved sixty days after public notice is given unless: (1) a consumer or consumer group requests a hearing within forty-five days of public notice and the commissioner grants the hearing or determines not to grant the hearing and issues written findings in support of that decision, (2) the commissioner on his own motion determines to hold a hearing, or (3) the proposed rate adjustment exceeds 7% of the then applicable rate for personal lines or 15% for commercial lines, in which case the commissioner must hold a hearing upon a timely request. The RRD reviews rate filings within these provisions and timeframes.

Public Viewing Rooms: As Proposition 103 states that all rating information provided to the commissioner must be available for public inspection, the RRD maintains public viewing rooms in San Francisco and Los Angeles.

Advisory Organizations: Although Proposition 103 eliminated rating organizations in California, advisory organizations may still exist. Advisory organizations file loss costs and forms with the RRD

Lines Regulated by Proposition 103: Overall the following lines of insurance are regulated by Proposition 103: Personal automobile, dwelling fire, earthquake, homeowners, inland marine, and umbrella; Commercial aircraft, automobile, boiler and machinery, burglary and theft, businessowners, earthquake, farmowners, some fidelity, fire, glass, inland marine, medical malpractice, miscellaneous, multi-peril, other liability, professional liability, special multi-peril, umbrella, and coverage under the United States Longshoremen's & Harbor Workers' Compensation Act.

Montana does not have statutory provisions similar to CA Proposition 103, but likely could enact something similar.

Other Potential Reforms

Testifying before Congress last month on behalf of the organization Public Citizen, Mr. Douglas Heller outlined seven discrete alternatives that would address some of the medical liability issues identified in SJR 32 and provide additional information or protection to the public. Heller's reforms appear below.⁴¹

- Reform medical board governance States should sever any remaining formal, debilitating links between state licensing boards and state medical societies. Members of medical boards (and separate disciplinary boards, where present) should be appointed by the governor, and the governor's choice of appointees should not be limited to a medical society's nominees. At least 50 percent of the members of each state medical board and disciplinary board should be well-informed and well-trained public members who have no ties to health care providers and who, preferably, have a history of advocacy on behalf of patients. The governor should appoint members to the Medical Board whose top priority is protecting the public's health, not providing assistance to physicians who are trying to evade disciplinary actions.
- Beef up medical board funding and staffing. State legislatures should permit medical boards to spend all the revenue from medical licensing fees, rather than being forced to give part to the state Treasury. The medical boards should raise their fees to \$500 a year. All boards could benefit from hiring new investigators and legal staff. Boards should employ adequate staff to process and investigate all complaints within 30 days, to review all malpractice claims filed with the board, to monitor and regularly visit doctors who have been disciplined to ensure their compliance with the sanctions imposed, and to ensure compliance with reporting requirements. They should hire investigators to seek out errant doctors, through review of pharmacy records, consultation with medical examiners, and targeted office audits of those doctors practicing alone and suspected of poor care.
- Require risk prevention. States should adopt a law, similar to one in Massachusetts, that requires all hospitals and other health care providers to have a meaningful, functioning risk prevention program designed to prevent injury to patients. Massachusetts also requires all adverse incidents occurring in hospitals or in doctors' offices to be reported to the medical board.
- Require periodic recertification of doctors based on a written exam and audit of their patients' medical care records.
- Institute experience rating. Doctors should be rated on performance for malpractice premiums. Doctors with numerous malpractice claims must be reviewed and higher premiums imposed so that they are discouraged from practicing and competent doctors do not subsidize them.
- Spread the risk more broadly. The number of classifications of doctor specialties for insurance rating purposes should be reduced. Risk pools for some are too small and thus overly influenced by a few losses and the concentration in a few specialties of doctors handling the highest risk patients. Often the high-risk patients are "referred up" from general practitioners who do not bear any of the risk.

⁴¹ Ibid.

Summary and Conclusion

Montana has enacted various "tort reforms" in the past 20 years that place the state among the "elite" with respect to medical liability litigation. Even as California's MICRA is sometimes referred to as "The Gold Standard", Montana's law is substantially the same.⁴² That said, it is difficult to argue or conclude that the status of Montana's "tort law" can have had anything but a positive effect on medical liability premiums and the availability of medical liability insurance.

Aside from tort reform, different students of the medical liability insurance "crises" have identified or proposed various alternatives as partial solutions to the crisis. These alternatives include variations on elements of tort law; educating judges and juries; creating a specialized court; implementing tools for normalizing jury awards; several different approaches for "alternative dispute resolution"; no-fault liability; establishing clinical practice guidelines; several insurance market interventions; Proposition 13-type (CA) requirements, restrictions, and authority; reforming the state medical board; enhancing the existing medical board and its staff; requiring risk prevention and periodic recertification of doctors; instituting experience ratings in medical liability insurance practices; and spreading the risk of medical liability more broadly. All told, there are at least a couple dozen options listed herein that have been enacted by, considered in, or proposed to various states' legislatures. There are likely to be many others.

Fundamentally, policymakers must determine to their own satisfaction the nature of rising medical liability insurance premiums and declining availability of medical liability insurance, then enact public policies to remedy concerns and problems.

SJR32\Interstate Comparisons 1.wpd

⁴² For a more detailed comparison, see Appendix C, "California vs. Montana: Detailed Comparison of Major Legal Provisions Related to Medical Malpractice" (Source: Medical Malpractice Summary, McCullough, Campbell & Lane, 205 North Michigan Ave., Suite 4100, Chicago, Illinois 60601-5925).

Appendix A

State Medical Liability Laws Table
Compiled by the
National Conference of State Legislatures
Denver, Colorado

2003

Appendix B

State Laws Chart I: Liability Reforms
American Medical Association
Advocacy Resource Center

June 17, 2003

Appendix C

California v. Montana Detailed Comparison of Major Legal Provisions Related to Medical Malpractice

Compiled from Medical Malpractice Summary Online
Internet URL for Montana: <http://www.mcandl.com/montana.html>
Internet URL for California: <http://www.mcandl.com/california.html>
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